vista eye centre

Dr. Larissa A. Derzko-Dzulynsky, MD, FRCSC
Dr. Nupura K. Bakshi, MD, FRCSC
Dr. Tiiu Hess, MD, FRCSC

UVEITIS PATIENT QUESTIONNAIRE

Name: ____

Date: ____

PERSONAL HISTORY:

Age: ____

Occupation (job): ______________________________________

Please answer the following questions to the best of your ability:

	YES	NO
In the past 10 years, have you travelled to any of the following destinations?		
South America		
Southern United States		
Africa		
Asia		
Middle East		
Have you ever owned a dog?		
Have you ever owned a cat?		
Do you ever eat uncooked or raw meat or sausages?		
Have you ever drunk water from a well, a stream, or a lake?		
Have you ever used intravenous drugs?		
Do you take oral contraceptives?		
Are you pregnant?		
Are you planning to conceive (become pregnant) in the near future?		

ALLERGIES:
Please list all food or medications allergies:

____
____
____
____

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PAST SURGERY:
Please list all eye surgery that you have undergone in the past along with approximate dates:

____
____
____
____

Please list all other surgeries that you have undergone and their approximate dates:

____
____
____
____
____

PAST MEDICAL HISTORY:

Have you ever had any of the following:

	YES	NO
Cancer		
Diabetes		
Hepatitis		
High blood pressure		
Anemia		
Pneumonia or pleurisy		
INFECTIONS:		
Tuberculosis (TB)		
Herpes (cold sores or genital herpes)		
Chicken pox		
Shingles		
HIV/AIDS		
Rubella		

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Mumps		
Measles		
Chlamydia or trachoma		
Syphilis		
Other STD (sexually transmitted disease)		
Leprosy		
Leptospirosis		
Lyme disease		
Histoplasmosis		
Candida or yeast infection		
Cryptococcus		
Coccidiomycosis		
Sporotrichosis		
Toxoplasmosis		
Giardia		
Toxocara		
Cystecercosis		
Trichinosis		
Whipple's disease		
IMMUNE or INFLAMMATORY CONDITIONS		
Arthritis		
Vasculitiis		
Lupus		
Scleroderma		
Crohn's disease or ulcerative colitis		
Reiter's syndrome		
Ankylosing spondylitis		
Behcet's disease		
Sarcoidosis		
Erythema nodosum		
Temporal arteritis		
Multiple sclerosis		
Retinitis pigmentosa		

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St. Joseph's Health Science Centre | Kensington Eye Institute | St. Michael's Hospital

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REVIEW OF SYSTEMS:

Over the past 6 months, have you experienced any of the following:

GENERAL HEALTH:

	YES	NO
Chills		
Fevers (persistent or recurrent)		
Night sweats		
Unusual fatigue		
Decreased appetite		
Weight loss		

NEUROLOGICAL SYSTEM

	YES	NO
Headaches – frequent of severe		
Numbness or tingling of any part of the body		
Paralysis or weakness of an body part		
Epilepsy or convulsions		
Psychiatric problems		
Dizziness or vertigo		

HEARING

	YES	NO
Decreased hearing or deafness		
Buzzing in your ears		

NOSE and THROAT:

	YES	NO
Mouth ulcers		
Recurrent nose bleeds		
Sinus problems		

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Hoarse voice or change in voice		
Dental or gum infections		

SKIN:

	YES	NO
Skin redness		
Skin ulcers		
White patches of skin		
Hair loss		
Tick bites		
Severe itching		
Change in skin colour		

RESPIRATORY SYSTEM:

	YES	NO
Chronic cough		
Cough with bloody sputum (coughing up blood)		
Shortness of breath		
Asthma or difficulty breathing		
Recurrent flu symptoms or recurrent bronchitis		

CARDIOVASCULAR SYSTEM:

	YES	NO
Chest pain		
Shortness of breath when lying flat		
Leg swelling		
Frequent bruising		
Frequent or excessive bleeding		

GASTROINTESTINAL SYSTEM:

	YES	NO
Difficulty swallowing		

Diarrhea		
Bloody stools		
Black stools		
Abdominal pain or burning		

MUSCULOSKELETAL SYSTEM:

	YES	NO
Join pain		
Join swelling		
Joint stiffness		
Pain or stiffness in back		
Muscle pain except after an accident		

GENITOURINARY SYSTEM:

	YES	NO
Incontinence		
Burning with urination		
Blood in urine		
Genital ulcers or sores		
Testicular pain		

FAMILY HISTORY:
Is there any one in your family who has any of the following (mother, father, grandparents, sisters, brothers, aunts and uncles):

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	YES	NO
Cancer		
Diabetes		
Arthritis		
Tuberculosis (TB)		
Sickle cell anemia		
Lyme disease		
Syphilis		
Eye disease (other than need for glasses)		
Disease of nervous system		
Disease of respiratory system (lungs)		
Immune system disease		
Ankylosing spondylitis		
Ulcerative colitis or Crohn’s disease		
Lupus		

Form completed by: ________________________________

Signature: ____

Date: ___________________________

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